

## **Nursing Services**

**Definition:** Nursing services are continuous or intermittent care provided by a nurse, licensed in accordance with the State's Nurse Practice Act, in accordance with the recipients' plan as deemed medically necessary by a physician.

**Providers:** Nursing services are provided by agencies or companies enrolled with SCDHHS to provide Nursing Services.

**Arranging for the Services:** Only a physician can determine if nursing services are needed and if needed, the amount needed and skill level required. The need for the service must be documented by the **Physician's Order for Nursing Services (MR/RD Form 28)** and in the recipient's plan. The skill level required (RN or LPN) must be noted and followed. A RN can provide care if the order is written for a LPN; however, the provider can only claim the LPN rate for that consumer when billing SCDHHS. A LPN **cannot** provide services when a RN is ordered by the physician.

Once it is determined that services are needed, the recipient/legal guardian should be provided with a list of enrolled Medicaid Nursing Services Providers and asked to select a company to provide the service. The Service Coordinator/Early Interventionist should assist as needed by the recipient/legal guardian. This offering of choice must be documented in the recipient's file.

For nursing services, one unit equals one hour of service. The rate paid for each unit depends upon the skill level required (i.e., RN is more expensive than LPN). Once the amount needed is determined, the needed units must be entered into the Waiver Tracking System (S68-LPN or S69-RN) and approval obtained before services can be authorized. **Please note, the maximum number of nursing units that can be funded by the Waiver is 60 hours per week when the services are provided by an LPN or 44 hours per week when services are provided by an RN. If a consumer's needs exceed these identified limits and there is no other funding source to provide the additional nursing (e.g. private insurance), please contact the appropriate MR/RD Waiver Coordinator for directions on how to proceed.**

For those recipients that have private insurance, Nursing Service Providers must bill the recipient's private insurance carrier prior to billing SCDHHS/Medicaid for all nursing services provided. MR/RD Waiver Nursing Services should not be billed to SCDHHS/Medicaid until all other resources, including private insurance coverage, have been exhausted. The Service Coordinator/Early Interventionist must first determine if the MR/RD Waiver recipient has private insurance and if the insurance policy covers nursing services. In no instance will SCDHHS pay any amount that is the responsibility of a third party resource. The MR/RD Waiver is the payer of last resort and maximum allowable limits as defined above apply.

The following procedures are to be followed when authorizing Nursing Services:

- **When private insurance covers all nursing services:**
  1. When the private insurance carrier pays for all nursing services deemed medically necessary by a physician, the Service Coordinator/Early Interventionist will indicate the hours of nursing service and private insurance carrier as the payment source in the recipient's plan and no authorization for service is necessary.

2. In no instance may the recipient be billed any cost sharing amount such as co-payments, deductibles and/or co-insurance.
- When private insurance covers a portion of nursing services:
    1. When the private insurance carrier pays for only a portion of the nursing service hours deemed medically necessary by a physician, the Service Coordinator/Early Interventionist will indicate the hours of Nursing Service the private insurance carrier will provide in the recipient's plan and indicate the private insurance as the payment source.
    2. For those additional hours not covered by the private insurance carrier, but deemed medically necessary, the Service Coordinator/Early Interventionist will issue an **Authorization for Service (MR/RD Form A-12)** for those hours not covered by private insurance and indicate the hours in the recipient's plan as funded by the MR/RD Waiver. Providers of Nursing Services must only bill SCDHHS/Medicaid for those hours of Nursing Services not covered by private insurance.
  - When private insurance covers none of the nursing services or the recipient does not have private insurance:
    1. When private insurance does not cover any Nursing Services deemed medically necessary by a physician or the recipient's does not have private insurance, the Service Coordinator/Early Interventionist will indicate the hours of Nursing Service in the recipient's plan as being funded by the MR/RD Waiver and complete the **Authorization for Services (MR/RD Form A-12)** for the hours needed not to exceed the applicable limits.

When sending the **Authorization for Services (MR/RD Form A-12)** to the selected Nursing Provider copy, the Service Coordinator/Early Interventionist must include a copy of the Physician's Order for services.

Upon receipt of the authorization, the company will begin providing services. After the first visit, the Nursing Service Provider will send to you their specific plan for providing nursing services and may suggest changes to the schedule that will affect the units authorized on **Authorization for Services (MR/RD Form A-12)**. If you agree with the suggested changes, the recipient's plan must be updated, the new information entered on the Waiver Tracking System and approved and a new authorization sent to the company reflecting the new units total and start date.

The company must notify you within two (2) working days of any significant changes in the recipient's condition or status. You must respond to requests from the company to modify the recipient's plan within three (3) days of receipt.

**Monitoring the Services:** You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the recipient's/family's satisfaction with the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following criteria should be followed when monitoring Nursing Services (RN/LPN).

- Must complete on-site Monitorship during the first month while the service is being provided unless a Supervisor makes an exception. An exception is defined in the following circumstances:
  - the service is **only provided** in the early morning hours (prior to 7:00 a.m.)
  - the service is **only provided** in late evening hours (after 9:00 p.m.)
  - The exception and approval by the Supervisor must be documented. **NO** other exceptions will be allowed.
- At least once during the second month of service
- At least quarterly thereafter
- Start over with each new provider
- Yearly on-site monitorship required.

This service must be monitored during a contact with the individual/family. It can be supplemented with contact with the service provider. In addition, you should review the nursing notes completed during activities with the individual during an on-site visit. Monitorship of the individual's health status should always be completed as a part of nursing monitorship. Some items to consider during monitorship include:

- Has the individual's medical status changed since your last contact? If the individual was receiving nursing for an acute condition, has the physician been consulted about the continuation of nursing services and the skill level required?
- Have there been any changes to the individual's specific nursing plan developed by the provider/Nurse? If so, does the Service Coordinator have a copy of the plan for the individual's record?
- Is the nursing provider providing the nursing services as authorized?
- Are they arriving on time to provide care to the individual? If the nursing provider does not show up to provide care to the individual, who is providing back-up care in the provider's absence?
- Is the individual satisfied with his/her provider of services?
- Does the nurse show him/her courtesy and respect when providing his/her care?
- Does nursing need to continue?
- What is the expected duration of services at the current level?

**Reduction, Suspension, or Termination of Services:** If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the consumer or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS**

**MR/RD WAVIER**

**Physician's Order for Nursing Services**

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

This patient requires the following care/treatment(s) that must be provided by a nurse licensed by the State of South Carolina.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

These services are necessary to maintain his/her health and prevent institutionalization. This patient requires \_\_\_\_\_ hours per \_\_\_\_\_ of nursing care to be provide by an:

RN ☐ or LPN ☐ (choose one).

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Name (Please print or type)

\_\_\_\_\_  
Address

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS  
MR/RD WAIVER**

**AUTHORIZATION FOR SERVICES**

**TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**TO:** \_\_\_\_\_

\_\_\_\_\_

**RE:** \_\_\_\_\_

**Recipient's Name**

/

**Date of Birth**

**Address**

**Medicaid #**

/ / / / / / / / / / / / /

*You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).*

**Prior Authorization #** / / / / / / / / / /

**Nursing Services:**

Total Number of Units Per Week to be Provided: \_\_\_\_\_ (one unit = 60 minutes)

☐ LPN Hours/Week (S9124): \_\_\_\_\_

☐ RN Hours/Week (S9123): \_\_\_\_\_

Start Date: \_\_\_\_\_

Service Coordinator/Early Interventionist: Name / Address / Phone # (Please Print):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Person Authorizing Services

\_\_\_\_\_  
Date

# **MEDICAID HOME AND COMMUNITY-BASED WAIVER SCOPE OF SERVICES FOR NURSING SERVICES**

## **A. Objective**

The objective of the services is to provide skilled medical monitoring, direct care, and intervention to maintain the client through home support. This service is necessary to avoid institutionalization.

## **B. Description of Services to be Provided**

1. The unit of service is one hour of direct nursing care provided to the client. The amount of time authorized does not include travel time.
2. The number of units and services provided to each client will be dependent upon the needs as established or approved by CLTC/DDSN.
3. Nursing services will provide skilled medical services as ordered by the physician and will be performed by a registered nurse (RN) or licensed practical nurse (LPN) who will perform their duties in accordance with state law.

## **C. Staffing**

1. The RN or LPN must meet the following requirements:
  - a. Supervised by an RN;
  - b. Licensed by the State of South Carolina to practice nursing;
  - c. Have at least two years experience in public health, hospital, or long term care nursing; and,
  - d. PPD Tuberculin Test

No more than ninety (90) days prior to employment, all staff having direct client contact shall have a PPD tuberculin skin test, unless a previously positive reaction can be documented. The two-step procedure is advisable for initial testing in those who are new employees in order to establish a reliable baseline. [If the reaction to the first test is classified as negative, a second test should be given one to three weeks after the first test. If the second test is classified as negative, the person is considered as being uninfected. A positive reaction to a third test (with an increase of more than 10mm) in such a person within the next few years, is likely to represent the occurrence of infection with M. Tuberculosis in the interval. If the reaction to the second of the initial two tests is positive, this probably represents a boosted reaction, and the person should be considered as being infected.]

Employees with reactions of 10mm and over to the pre-employment tuberculin test, those with newly converted skin tests, and those with symptoms suggestive of tuberculosis (e.g., cough, weight loss, night sweats, fever, etc.) regardless of skin test status, shall be

given a chest radiograph to determine whether tuberculosis disease is present. If tuberculosis is diagnosed, appropriate treatment must be given, and the person must not be allowed to work until declared noncontagious by a licensed physician.

Routine chest radiographs are not required on employees who are asymptomatic with negative tuberculin skin tests.

Employees with negative tuberculin skin tests shall have an annual tuberculin skin test.

New employees who have a history of tuberculosis disease and have had adequate treatment shall be required to have certification by a licensed physician or local health department TB staff (prior to employment and annually) that they are not contagious. Regular employees who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared noncontagious.

Preventive treatment should be considered for all infected employees having direct client contact who are skin test positive but show no symptoms of tuberculosis. Routine annual chest radiographs are not a substitute for preventive treatment. Employees who complete treatment, either for disease or infection, are exempt from further routine radiographic screening, unless they develop symptoms of tuberculosis. Employees who do not complete adequate preventive therapy should have an annual assessment for symptoms of tuberculosis.

Post exposure skin tests should be provided for tuberculin negative employees within twelve (12) weeks after termination of contact to a documented case of infection.

Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, S.C. 29201 (phone (803) 898-0558).

2. An LPN and RN must have the following training:
  - a. The provider assures that the nurse has adequate experience and expertise to perform the skilled services ordered by the physician; and,
  - b. The provider will provide for a minimum of six hours relevant in-service training per year (based on date of employment) for each nurse.
3. In addition, services provided by a LPN must also adhere to the following:
  - a. The RN supervisor will initially assess the client and complete a plan of care for the LPN to follow;
  - b. The RN supervisor will evaluate the LPN's competency skills at a minimum of every six months or more often as deemed necessary by the RN. The RN will observe the LPN providing the necessary care to the specific client as a part of the evaluation of the LPN's competency skills;
  - c. The RN supervisor will be accessible to the LPN via beeper/phone at all times the LPN is on duty; and,

- d. The RN supervisor will decide the frequency of supervisory visits based on his/her professional knowledge of the client's situation, health status, and the LPN's competency skills; however, this may be no less frequent than every 90 days. These visits will include a re-evaluation of the client's condition as well as updating of the plan of care. The CLTC case manager/DDSN service coordinator must be notified in writing of the prescribed frequency of the supervisory visits, as well as receive a copy of written supervisory reports.

D. Conduct of Service

1. An individual client record must be maintained.
2. The provider will be responsible for procuring the direct care skilled nursing orders from the physician.
3. Nursing services must begin on the date negotiated by CLTC/DDSN and the nursing services provider.
4. After the completion of the first nursing visit, the provider must send the plan of care to CLTC/DDSN which includes treatment plan and goals. If applicable, recommendations to change the service schedule from the initial authorization may be sent to CLTC/DDSN.
5. The provider must have a back up plan in the event the scheduled nurse cannot complete the client visit.
6. Nursing services must not be provided prior to the authorized start date.
7. The provider will notify CLTC/DDSN within two working days of the following client changes:
  - a. Client's condition has changed and the Plan of Service no longer meets the client's needs or the client no longer needs nursing services;
  - b. Client is institutionalized, dies or moves out of the service area;
  - c. Client no longer wishes to receive the nursing service; or
  - d. Knowledge of the client's Medicaid ineligibility or potential ineligibility.
8. The provider will maintain a record keeping system which establishes an eligible client profile in support of units of nursing services. A daily log will reflect the services provided by the nurse and the time expended for this service.
9. The provider must develop and maintain a state approved policy and procedure manual which describes how it will perform its activities in accordance with the terms of the contract.
10. CLTC/DDSN will authorize nursing services by designating the amount, frequency, and duration of service for clients in accordance with the client's Plan of Service. This documentation will be maintained in the client's file.

11. CLTC/DDSN will review the client's Plan of Service within three days of receipt of the provider's request to modify the plan.
12. CLTC/DDSN will notify the provider immediately if a client becomes medically ineligible for services and will make every effort to verify Medicaid eligibility on a monthly basis. However, the provider should refer to the language in the DHHS Community Long Term Care Services Provider Manual on pages 1-5 regarding the provider's responsibility in checking the client's Medicaid card.

E. Administrative Requirements

1. The provider agency shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the provider agency. The provider agency shall notify DHHS within three working days in the event of a change in the agency administrator, address, or telephone number.
2. The organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on client care level staff shall be set forth in writing. This shall be readily accessible to all staff and shall include an organizational chart. A copy of this shall be forwarded to DHHS at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the provider agency and to DHHS.
3. The provider agency must have written by-laws or equivalent which are defined as "a set of rules adopted by the provider agency for governing the agency's operations." Such by-laws or equivalent shall be made readily available to staff of the provider agency and shall be provided to DHHS upon request.
4. Administrative and supervisory functions shall not be delegated to another agency or organization.
5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the provider agency. A listing of the members of the governing body shall be made available to DHHS upon request.
6. An annual operating budget, including all anticipated revenues and expenses related to items which would under generally accepted accounting principles be considered revenue and expense items, must be submitted to DHHS prior to the signing of the initial contract with DHHS. The provider agency must maintain an annual operating budget which shall be made available to DHHS upon request.
7. The provider agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the provider agency shall furnish a copy of the insurance policy to DHHS.

April 12, 2001